College of Human Medicine
Small Group Rating Form

OVERALL RATING ____

4 = Deserves honorable mention for outstanding work

3 = Clearly meets expectations

2 = Meets most expectations, but has an area where improvement is needed

1 = Significant deficiencies noted

CE = Can't evaluate. Not enough behavior observed to judge

Note: An overall rating of **2** or **1** requires a meeting with the student and group preceptor, and filing a written remediation pl with the module coordinator. The overall rating need not be an average of the other ratings, as the preceptor may judge tl differential weights need to be assigned in different categories.

Comments:

Preceptor Signature | Date | Student Signature | Date

PLEASE RETURN TO:

June 1998

Readings: Session I

Readings for Session I

SPIRITUALITY AND MEDICINE

J. Foglio, D.Min.

"An essential unity of art and science, of wisdom and technique, is left unresolved when spirituality is not addressed in medicine."[1]

Although spirituality cannot be defined with one exclusive definition, its elements can be described to avoid the conceptual vagueness that is usually associated with spirituality, a vagueness of the meaning and the universality of spirituality.

The spiritual can be described as an umbrella of our own non-physical nature concerned with such supreme values as love, meaning, beauty, hope, and truth. Our values, purpose of life, our conception of peace, compassion, personhood, our understanding of death and grieving, as well as our own self-reflection are all expressions of our spirit and are invaluable to our understanding of the spirituality of self and others.

We must also recognize the universality of spirituality and support religiously-spiritual and or secularly non-religiously spiritual students at MSU discern and exercise their spirituality in unique and innovative ways. I was especially gratified as a preceptor in HM 548, the Spirituality selective of this Humanities Course to have a self-described atheist in CHM Year II confide that he was happy to have re-found his spirituality. He considered himself not religious, but vitally concerned with his spirituality, and the values, and person meanings so central to his well-being.

Besides the fostering of human values spirituality concerns the personal meanings that are attached to experience. Howard Brody concludes that suffering is produced and alleviated

primarily by the meaning one attaches to one's experience.[2] Alluding to his experience as a prisoner at Aushwitz, Viktor Frankl wrote: "Again and again we have seen that on appeal to continue living, to survive the most unfavorable conditions, can be made only when one such survival appears to have meaning. That meaning must be realized by this person alone."[3]

In 1977, George Engel[4] used his model of health, the biopsychosocial, to counteract the Cartesian conception of the dicotomization of body and spirit. This system's model insists that an individual's health depends on the well-being and integration of the physical, psychological and relational and not on any one of the systems alone.

Further, we concur with John Hiatt that spirituality as an integrating function for the individual, can help bring the seemingly disparate parts of the personality and the fragmented nature of experience together into a single whole.[5] John Carr observes that the biopsychosocial model of understanding wellness has sensitized physicians, health care professionals and those who understand the healing arts to a diversity of variables linearly related, but the model does not provide an integrating framework.[6] Spirituality is seen as an integrative force of the biopsychosocial's three systems rather than a separate system of its own, i.e., the biopsychosocialspiritual. Spiritually can be an important element of this integration and as such, it deserves attention in the art of medicine.

Spirituality's unique place in the understanding of health and well-being is in its emphasis on human values and human personal meanings that are vital to one's life. Since spirituality concerns these essential values and personal meanings that are vital to the well-

being of both patient and health care professional, spirituality should be given curricular attention at all stages of the education and training of physicians and other health care professionals.

Our CHM Department of Family Practice fosters emphasis on the necessity of spirituality in primary care, by the inclusion of the teaching of spirituality at the pre-clinical, ("Spirituality: A Vital Component of Well-Being", a selective in the Humanities Block, HM 548, Spring Semester, Year II) the clinical (Saginaw Community's Quarterly Conferences, "Spirituality and Human Values in Medicine"), and residency (Spirituality component of the Psychosocial Rotation for Interns in the Family Practice Residency at St. Lawrence Hospital) levels of medical education as well as in MSU undergraduate education (Lectures and the assignments of a paper in the training of student Olin Health Care Advocates serving MSU's residence halls).

We conclude, therefore, that the spirit of the human person is a vital part of the nature of humaneness and as such needs attention if we are to understand, nurture, and support the healing of persons. Spirituality is an important part of the humanities that will aid in this venture. Abraham Maslow wrote in 1968, "The human being needs a framework of values, a philosophy of life, a religion or religion-surrogate to live by in about the same sense that he/she needs sunlight, calcium, or love. We need a validated, usable system of human values that we can believe in and devote ourselves to (be willing to die for)."[7]

END NOTES

[1] Ellison as quoted in Barker, "Spiritual Well-Being in Appalachian Women".

[2] Brody, Howard, The Healer's Power.

[3] Frankl, Viktor, Doctor of the Soul.

[4] Engel, G.L., "The Need for a New Medical Model: A Challenge for Biomedicine".

[5] Hiatt, John, "Spirituality, Medicine, and Healing."

[6] Carr, John, "Basic Behavioral Science in Medical Education: The Need for Reform."

[7] Maslow, Abraham, (cf. Brenner, "The Essence of Spirituality", Spiritual Dimensions of Nursing Practice.

SPIRITUALITY DESCRIBED

Definitions of the dimension of spirituality are numerous: a principle; an experience; a way of being; a mystery; and a God experience (Barshinger 1979; Colliton 1981; Egan 1984; Kenner, Guzzetta, and Dossey 1985; May 1974). One might begin by asking, "What is spirituality to me? Spirituality is my being; my inner person. It is who I am - unique and alive. It is me expressed through my body, my thinking, my feelings, my judgments, and my creativity. My spirituality motivates me to choose meaningful relationships and pursuits. Through my spirituality I give and receive love; I respond to and appreciate God, other people, a sunset a symphony, and spring. I am driven forward, sometimes because of pain, sometimes in spite of pain. Spirituality allows me to reflect on myself. I am a person because of my spirituality - motivated and enabled to value, to worship, and to communicate with the holy, the transcendent."

A review of concepts and ideas by several authors provides one with the following descriptors of both spirit and spirituality. The reader is encouraged to reflect on these descriptors to gain some understanding and appreciation of their diversity.

Person's spirit:

- The Imago Dei (image of God) within every person, making one a thinking, feeling, moral, creative being able to relate meaningfully to God (as defined by the person), self and others.
- A basic human drive for bonding with the transcendent.
- An animating, intangible principle that gives life to the physical organism. . . . [it] integrates and transcends all other dimensions of the person.
- The literal breath of life.
- The real person, the part of us nobody can see, the part that doesn't die. . . the inside you. . .
- Provides the person with a capacity for God consciousness, however God is defined.

Person's spirituality:

- The core of one's being; a sense of personhood; what one is and is becoming.
- Concerned with bringing meaning and purpose to one's existence; what or who one ought to live for.
- Feeling level of experience of God as a transcendent and/or personal being.
- Intangible motivation and commitment directing toward ultimate values of love, meaning, hope, beauty and truth.
- A supreme experience.
- Trust relationship with/or in the transcendent that provides bases for meaning and hope in life's experiences and love in one's relationships (Bayly 1969, p. 47; Allen and Schoolcraft 1984; p. 247; Dickinson 1975; McSherry 1983, p. 217).

These descriptors suggest both a vertical and horizontal dimension to the person's spirituality. The vertical dimension has to do with the person's transcendent (beyond and/or outside self) relationship, the possibility of person-relatedness to a higher being - God - not necessarily as defined by a particular religion. Horizontal * p. 2

Within the humanistic framework, however, the God concept does not constitute a transcendent being or a religious beliefs framework. Instead, the person has consciously or unconsciously chosen values that become the supreme focus of life and/or around which life is organized. These supreme values motivate people's life-style toward fulfillment of their goals, needs, and aspirations. This self-actualization focus encourages a person toward a spiritual quest for being on a human plane only.

Maslow (1968), a humanist, writes:

> The human being needs a framework of values, a philosophy of life, a religion or religion-surrogate to live by, and understand by, in about the same sense that he needs sunlight, calcium, or love. . . We need a validated, usable system of human values that we can believe in and devote ourselves to (be willing to die for) (p. 206).

As will be seen later, a person's perception of and experience with the transcendent will in great measure influence how that person views life and copes with life's crises of illness, suffering, and loss.

The vertical, God-related dimension does not stand alone. Spirituality is, in a sense, a two-dimensional concept. The horizontal facet reflects and "fleshes out" the supreme value experiences of one's relationship with God through one's beliefs, values, life-style, quality of life, and interactions with self, others, and nature.

Spirituality is such a complex concept. It might be helpful to depict these dimensions in a visual model (Fig. 1-1).

As one might observe, there is a continuous interrelationship between and among the inner being of the person, the person's vertical relationship with the transcendent/God or whatever supreme values guide the person's life and the person's horizontal relationships with self, others, and the environment. These relationships are depicted by the inner dotted lines in Figure 1-1. The person's relationships are grounded in expressions of love, forgiveness, and trust and result in meaning and purpose in life. Noted above and below the model depicting the inner person are factors that continuously influence the well-being or distress of the person's spirituality (see chapters on development, dying, and chronic illness).

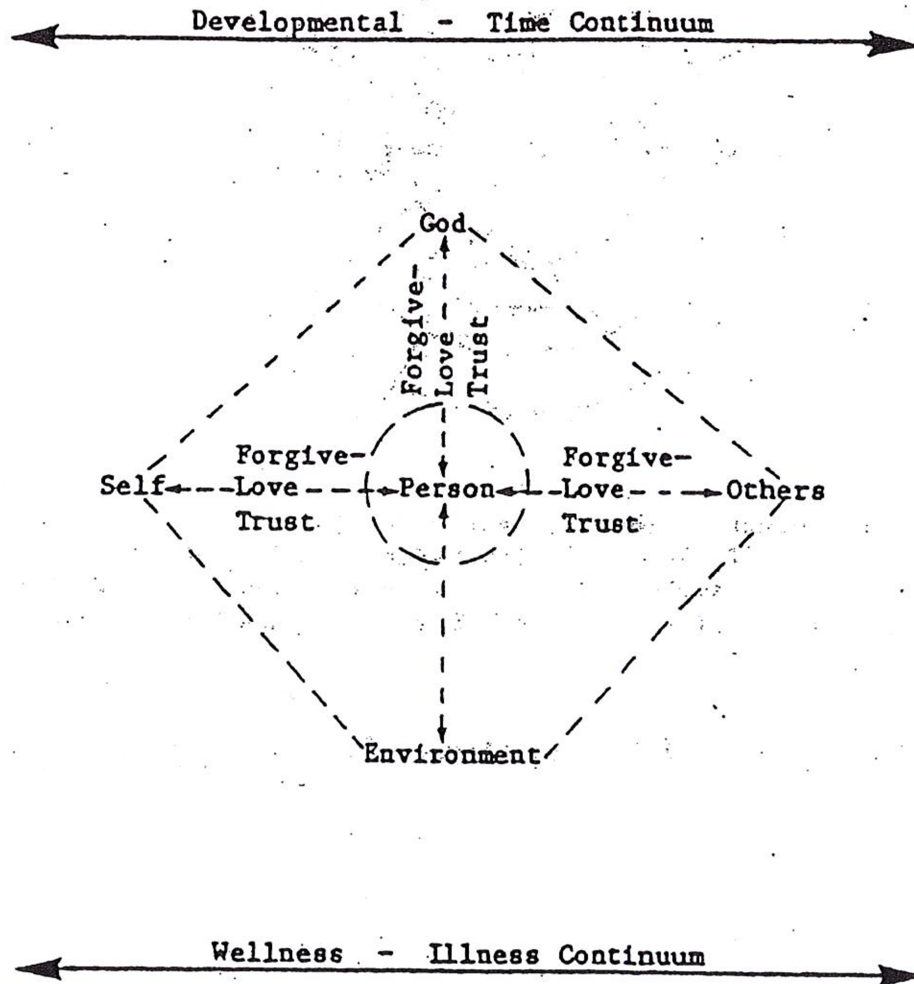
SPIRITUALITY-HOLISM

A person's human spirit does not reside in a vacuum. As suggested previously, it is housed in a physical body. The person is a whole being and cannot be separated into segments for diagnosis and care. People are more than and different from the sum of their parts. Recent emphasis in psychosomatic medicine reveals that our beings - body, mind, and spirit - are dynamically woven together, one part affecting and being affected by the other parts. Figure 1-2 depicts an adaptation of a model developed by Stallwood (1975) as an illustration of a person's wholeness.

The following descriptions are meant to clarify the meaning of each circle in the model and the interrelatedness of the identified parts. The outer circle represents the physical body. The body is the person seen and experienced by others. It allows the person to be in touch with the world through the vehicle of the senses (touch, taste, hearing, seeing, smelling). The second circle represents the psychosocial - that part of the person that gives one self-consciousness and personality through the emotions, the intellect, the

Fig. 1-1

Figure 1. The Person's Spiritual Inter-relatedness

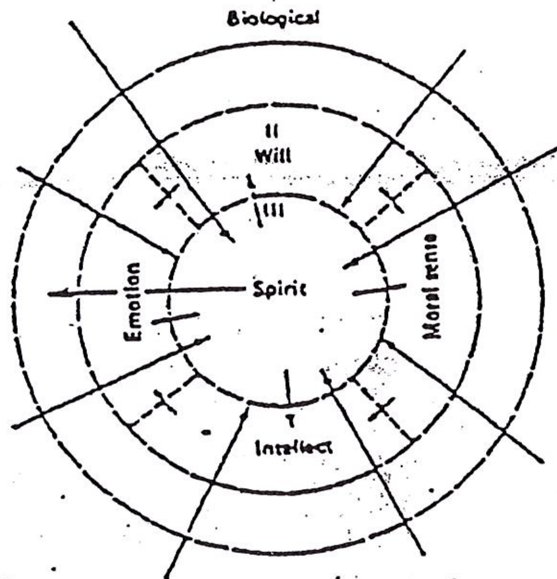


Key: ——— Inter-relatedness via forgiveness, love and trust resulting in meaning and purpose in life.

From Spiritual Dimensions of Nursing Practice by Verna Carson Brenner.

Fig. 1-2

2. Conceptual model of nature of man: (person)



* Conceptual model of nature of man
  I. Biological: Five senses, world-conscious.
  II. Psychosocial: Soul, self-conscious; self-identity.
  III. Spirit: God-conscious, relatedness to deity.

Source: Stallwood in Beland and Passos, Clinical Nursing, p. 1087.

moral sense, and the will. The innermost circle, the spirit, is the most difficult to comprehend because of its mystery and empirically indefinable nature. The spirit is that part previously described as pervading all other dimensions of the person. Within this spiritual part lies the potential for consciousness of and relatedness to God.

The human person is and functions as a dynamic whole. This is depicted in the model by the broken lines and arrows. The body influences and is influenced by the psychosocial and spiritual dimensions. The psychosocial dimension of the person expresses itself through the body, the biological dimension. The spirit expresses itself via the total being - the psychosocial and biological dimensions. The human spirit in a very real sense unifies the whole person and potentially promotes inner harmony or shalom, meaning health, ". . .a peace of God-centered human wholeness" (McSherry 1983, pp. 218-219).

Clinical Examples

Orphia, previously mentioned, helps to illustrate both models and explanations. Behavior demonstrated that her living spirit expressed itself via her other two dimensions, the psychosocial and the biological. Orphia expressed her psychosocial dimension in tears, bodily expressions of sadness, and joy by squeezing another's hands or smiling. Her will (decision maker) and power to choose were revealed in her choice of and active participation in imagery, prayer, and meditation to relieve pain and reduce her fears. her conscience (moral sense), discernment of "shoulds" and "oughts," motivated her to maintain those practices that would encourage positive interpersonal relationships ("journaling" or letter writing and telephone calls). She reasoned out through her thought processes how God was helping her, how to apply passages of Scripture to her illness experience, and she shared her feelings verbally with the nurse and others. Orphia had a conscious, loving, trusting relationship with a personal God. It was the integration of the vertical relationship with her God into her being and life-style that gave meaning and hope to horizontal relationships with herself and with others and in large measure influenced her outlook and her coping with the tragedy of illness.

Another clinical example provides an excellent illustration of a dormant spirit creatively affected by another crisis. Mr. Rogers is a 60-year-old man with metastatic carcinoma. He has been in and out of hospitals for the past 3 months. Presently he is in the hospital, lethargic but conscious. "I've had it. . . The hardest thing is just waiting and suffering. . . I know it sounds awful to say it, but I want to die." As the nurse explored the meaning of what it is like to die, he continued, "I'm really afraid to die." In answer to the nurse's question, "What would help you cope with your suffering. . . psalm 23. . . prayer. . . or a back rub? Mr. Rogers replied, ". . .I'm not religious. I was brought up in a church and I went on Sundays but I don't want to go running to God now. It's not fair of me. I've ignored God up until now. But please pray for me in your own way wherever you want, but not here."

Mr. Roger's sense of isolation and fear seemed to motivate him to gingerly yet with a ray of hope grasp onto the possibility that maybe, just possibly, there is something or someone to guide him through and bring him some relief in the last stage of life, in his experience of pain and death. This man's crisis brought awareness of a need for bonding with the transcendent, which seemingly had not taken place yet. The crisis also brought Mr. Rogers face to face with the fear of whom one was to love and how that love is received and returned.

SPIRITUALITY AND RELIGION – ITS UNIVERSALITY

One of the major difficulties affecting an interpretation of spirituality seems to be the question of universality. Spirituality is a dimension within every person – religious, atheist, or humanist. Spirituality is frequently equated with a religion or religions, even a particular doctrine or belief. Spirituality and religion may be used synonymously but are not necessarily synonymous.

Although most people continue to satisfy their spiritual needs through a particular religious framework or religious denomination, religion – with its beliefs, rituals, and communal experiences – serves as a vehicle for the expression of the person's spirituality (Allport 1950; Jourard 1974; Maslow 1968). Each person seeks an object of focus for worship, whether that be an unconscious God, created beings, or a personal God. We seek to integrate the supreme values of life – trust, hope, meaning, love, and forgiveness – so as to meet our needs and enjoy the fullest life for ourselves in relationships with others.

People do give spiritual expression through creativity and sensuous experiences. Frankl (1952) writes of spirituality as a person giving meaning to his or her life by creative values – opportunity to achieve tasks; by experiential values that make possible the experiencing of goodness, beauty, truth, or a relationship with a special other; or ultimately, by attitudinal values – the outlook or attitude a person chooses to take toward unavoidable suffering. Ebersole and Hess (1985) believe that possibilities for peak experiences and self-transcendence – that which gives life meaning – can be found in religion, art, sharing of legacies, music, and even a meal. Brown (1977) shared some ice cream with an elderly gentleman client of hers. She says, "As we ate together, we discussed his life experiences as a young man. . . [changes] and . . .future directions. . . We only spent an hour together, but it was a golden hour for him, as well as for me. . . It had given us both hope in the context of mutuality" (p. 11).

Even "humor is transcendent because it momentarily removes one from an isolated personal state to join in surprise at the ludicrous situations of human beings. . . [perhaps] strength and inner resources can be measured by one's appreciation of the humor in life" (Ebersole and Hess 1985, p. 766).

Pluralism

The United States is a land of diverse cultures, life-styles, religions, and philosophies. Each of us benefits from this pluralism. There is richness in diversity, especially when such diversity is allowed the freedom of expression. Few of us have felt the fear and constraint of repression because of conflict between divergent personal and majority group values and beliefs. Diversity will flourish where freedom of expression and acceptance exist.

Nurses practice in such a diverse environment. Some nurses and clients express their spirituality through a very active trust in a personal God and loving Christ, who provides them with meaning and hope in the midst of pain and illness, as in Orphia's case. One client diagnosed as having lung cancer described himself as an agnostic. "I believe in a higher being (God) who rules. if it's my time, it's my time. I don't believe in the church anymore. I believe in prayer. It seems to help." He described himself as often keenly aware of the presence of God or a divine being. Relatedness with God but not religion was an important part of his philosophy of life. The most significant value in his life was his relationship with his wife and family.

Nurses and clients who choose values other than a creator-personal God may express their trust and hope in themselves. "I am the master of my fate, the captain of my soul." One gentleman with a Ph.D. in psychology, who had lung cancer, said that science provides the answers, not religion. "I don't have any spiritual beliefs. . . it's my opinion; I have to make a choice." The supreme value that seemed to bring meaning and organization to this gentleman's life was science and its application to the processes of life.

An atmosphere that allows such diversity of spiritual expression also can be conducive to personal inquiry and exploration, as in Mr. Rogers's case. Present circumstances may bring to the client's awareness a previously unconscious spiritual need. The following questions might encourage this inquiry:

- Is God significant to you?
- If so, could you tell me how?
- What is your source of strength and hope?
- Do you ever ask, "Why is this happening to me?"

The preceding material was taken from the book Spiritual Dimensions of Nursing Practice, Chapter 1, pp. 6-13, by Verna Carson Brenner.

Readings: Session II

Readings for Session II

The Spiritual Dimension:
Is This a Doctor-Patient Realm

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The Spiritual Dimension: Is This a Doctor-Patient Realm?

As primary care practitioners, we are involved in the daily struggles and pain of our patients and families as they search for answers about the meaning of illness, suffering and interpersonal difficulties. Frequently, they ask penetrating questions, such as "Why is this happening to me?" or "I was so wrong in getting pregnant; is this punishment for what I did?" or "I'm sick and miserable, so how can God be a loving God?" The very nature of life, death, and of God's meaning in their lives may become critically important during such times. However, because of the increasingly complex diagnostic and technological demands on physicians and nurses, as well as limited knowledge about the integration of the spiritual with biopsychosocial care, providers often don't have the time or skill to hear and respond to such questions.

Recently, a number of authors have encouraged physicians and nurses in primary care to examine the spiritual/religious dimension of patients[1-4]. By understanding and addressing this dimension these authors suggest that healing may be facilitated, patient-provider relationships strengthened, compliance improved and, in fact, time and resources saved for provider and patient in the form of fewer visits and diagnostic tests.

However, among others, two very practical questions remain unanswered: "Do patients consider spiritual matters to be important in their lives?" and "Do patients want their primary care providers to address the spiritual dimension of their lives?" Hamadeh's case study[2] suggests that some patients may hesitate to discuss such matters with their physician. However, Kennison[3] and Ashbrook[5] report that patients usually experience the spiritual as integrated with the physical and emotional and actually often want to discuss how the spiritual has meaning during their illness or in their life experiences.

These questions were examined more directly in the form of null hypotheses which were tested in a descriptive study involving 397 patients from three different family medicine practices within the same upstate New York urban community, one being a university affiliated family medicine residency practice. The questionnaire was an original instrument and revealed good internal reliability.

Results for the three different sites were that 50 to 88% of respondents strongly agreed or agreed that spiritual matters were important in their lives. From 40 to 78% of respondents strongly agreed or agreed that their physicians should address spiritual matters. Several significant differences in the characteristics of the subjects from each site were the bases for understanding the range of differences in site responses. Analyses of specific subscale and item responses indicated that certain types of physician interventions were more acceptable to patients than others.

Conclusions are that a substantial number of patients recognize the importance of spiritual matters in their lives and want their primary care providers to address such matters.

Implications for primary care practice and education are discussed. Practice recommendations are that a spiritual assessment be included in the patient evaluation process, and that patient questions, such as the meaning and purpose of life, unforgiveness, and guilt, be considered as spiritual matters that may require intervention or referral. Examples are provided. Recommendations for curriculum development and education are that a) a conceptual framework for understanding and investigating spirituality be developed and b) the content and process of spiritual assessment and intervention, including the categories of spiritual matters frequently presented by patients, be progressively included in the training programs for all primary care providers.

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[1]Foglio JP & Brody H: Religion, faith, and family medicine. J Fam Pract 1988; 27:473-474.

[2]Hamadeh G: Religion, magic, and medicine. J Fam Pract 1987; 25: 561-568.

[3]Kennison MM: Faith: an untapped health resource. J Psych Nurs 1987; 25:28-30.

[4]King DE, Sobal J, DeForge BR: Family practice patients' experiences and beliefs in faith healing. J Fam Pract 1988; 27: 505-508.

[5]Ashbrook JB: The impact of the hospital situation in our understanding of God and man, in Belgum D (ed) Religion and Medicine: Ames, Iowa, Iowa State University Press 1967:61-80.

WILLIAM A. HENSEL, M.D., and TERESA L. RASCO

Storytelling as a Method for Teaching Values and Attitudes

Abstract—Storytelling is not widely accepted as a teaching method in medical education, sometimes for valid reasons that are explained by the authors. Yet clinician-teachers who choose and tell stories appropriately—especially if these are stories of their own clinical experiences—can stimulate their students to examine their values and attitudes in ways that would be hard or impossible to achieve by other methods. The present article, which contains a story of the type advocated, shows how storytelling can help students and residents discuss and overcome their crises of professionalization and come to grips with the troubling aspects of the doctor-patient relationship. The authors maintain that storytelling allows educators to bring the discussion of values and attitudes to where students are most likely to appreciate and understand the message—the clinical encounter. *Acad. Med.* 67(1992):500-504.

Storytelling in medical education poses an interesting paradox: stories abound, yet storytelling is looked upon as an inefficient and even inappropriate teaching method. It is our premise that part of the reason for this lack of acceptance has to do with the confusion over what is meant by the terms *story* and *storytelling*. The purpose of this paper is to help clear this confusion, and to show that when stories are personal, well-focused, and derived from the immediate clinical setting, they are an effective way to teach—and to help balance the technically lopsided education students now receive.

To achieve our purpose, we review the literature on storytelling and discuss the problems inherent to the medium. We then outline some of the educational issues that storytelling may address. Finally, to make clear what types of stories we feel are effective, we give an example and describe how such a story can be incorporated into clinical teaching to create an environment in which students and residents can develop the foundations for healthy doctor-patient relationships and professional values and attitudes.

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Existing Literature

The existing literature on stories and storytelling in medical education is sparse and paints a picture that is too fragmented to be of much practical use. Although he did not use the term "stories," Balint and his group of general practitioners used presentation and discussion of actual cases to convey the dynamics of the doctor-patient relationship. His text on the subject has since become a classic in medical literature.[1] William Carlos Williams had used clinical stories to express the magnitude of this relationship and other aspects of doctoring two decades earlier.[2] Educators have drawn from both of these men to discuss what Coles describes in his introduction to *William Carlos Williams: The Doctor Stories* as "the big things . . . of the physician's life—the great unmentionables that are yet everyday aspects of doctoring,"[2] and what we would call the values and attitudes needed to become a good physician.

In Hunter's estimation, "narrative occupies a great deal of the physician's professional interaction, even—perhaps especially—in the academic medical center."[3] Yet, aside from Balint and others who have formed and reported case-centered discussion groups, there is a paucity of journal articles and books documenting the use of stories for teaching purposes.[1,3-7] This absence in itself would not be bothersome, given that the common is often overlooked. But not only is storytelling ignored in this manner—it is maligned. As Hunter observes, the word "anecdote" ranks among the most pejorative in medicine.

Problematic Nature of Stories

This questionable reputation is not entirely undeserved. First of all, clinical stories offer poor descriptions of disease and disease processes, particularly when compared with rigorous clinical trials. As Hunter notes, "insofar as they purport to convey knowledge, [stories] are regarded as antiscientific." But, as she and Simpson point out, just because stories do not measure up to the same standards as those used to judge investigative research does not mean they are without scientific or educational value.[3,8]

The second reason for the story's notoriety relates specifically to the use of stories in medical education. Williams alluded to this when he wrote that "the relationship between physician and patient, if it were literally followed, would give us a world of extraordinary fertility of the imagination which we can hardly afford."[2] In short, the richness and scope of the narrative makes it difficult to break down into teachable quanta. Hunter supports this idea when she explains that stories often exist on multiple levels: doctor as teacher, doctor as confessor, the perils of a therapy, or the unlikely diagnosis, to name a few.[3] Stein and Apprey describe the "story behind the story: of clinicians, students, teachers, patients, and families . . ."[7]

In addition to having several layers